837 Health Care Claim : Institutional

HIPAA/V5010X223A1/837: 837 Health Care Claim : Institutional

Encounter Version: 1.0

Author:	**Edifecs, Inc**
Company:	**Bureau of TennCare**
Publication:	**3/22/2011**
Trading Partner:	**MCOs**
Notes:	

Table of Contents

837 Health Care Claim : Institutional

Functional Group=HC

Purpose: This X12 Transaction Set contains the format and establishes the data contents of the Health Care Claim Transaction Set (837) for use within the context of an Electronic Data Interchange (EDI) environment. This transaction set can be used to submit health care claim billing information, encounter information, or both, from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where coordination of benefits is required or between payers and regulatory agencies to monitor the rendering, billing, and/or payment of health care services within a specific health care/insurance industry segment. For purposes of this standard, providers of health care products or services may include entities such as physicians, hospitals and other medical facilities or suppliers, dentists, and pharmacies, and entities providing medical information to meet regulatory requirements. The payer refers to a third party entity that pays claims or administers the insurance product or benefit or both. For example, a payer may be an insurance company, health maintenance organization (HMO), preferred provider organization (PPO), government agency (Medicare, Medicaid, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), etc.) or an entity such as a third party administrator (TPA) or third party organization (TPO) that may be contracted by one of those groups. A regulatory agency is an entity responsible, by law or rule, for administering and monitoring a statutory benefits program or a specific health care/insurance industry segment.

Heading:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes	Usage
0050	ST	Transaction Set Header	M	1			Required
0100	BHT	Beginning of Hierarchical Transaction	M	1			Required
LOOP ID - 1000A					**1**	**N1/0200L**	
0200	NM1	Submitter Name	O	1		N1/0200	Required
0450	PER	Submitter EDI Contact Information	O	2			Required
LOOP ID - 1000B					**1**	**N1/0200L**	
0200	NM1	Receiver Name	O	1		N1/0200	Required

Detail:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes	Usage
LOOP ID - 2000A					**>1**		
0010	HL	Billing Provider Hierarchical Level	M	1			Required
0030	PRV	Billing Provider Specialty Information	O	1			Situational
0100	CUR	Foreign Currency Information	O	1			Situational
LOOP ID - 2010AA					**1**	**N2/0150L**	
0150	NM1	Billing Provider Name	O	1		N2/0150	Required
0250	N3	Billing Provider Address	O	1			Required
0300	N4	Billing Provider City, State, ZIP Code	O	1			Required
0350	REF	Billing Provider Tax Identification	O	1			Required
0400	PER	Billing Provider Contact Information	O	2			Situational
LOOP ID - 2010AB					**1**	**N2/0150L**	
0150	NM1	Pay-to Address Name	O	1		N2/0150	Situational
0250	N3	Pay-To Address - ADDRESS	O	1			Required
0300	N4	Pay-to Address City, State, ZIP Code	O	1			Required

LOOP ID - 2010AC					1	N2/0150L	
0150	NM1	Pay-To Plan Name	O	1		N2/0150	Situational
0250	N3	Pay-To Plan Address	O	1			Required
0300	N4	Pay-To Plan City/State/Zip Code	O	1			Required
0350	REF	Pay-To Plan Secondary Identification	O	1			Situational
0350	REF	Pay-To Tax Identification Number	O	1			Required

LOOP ID - 2000B					>1		
0010	HL	Subscriber Hierarchical Level	M	1			Required
0050	SBR	Subscriber Information	O	1			Required
LOOP ID - 2010BA					**1**	**N2/0150L**	
0150	NM1	Subscriber Name	O	1		N2/0150	Required
0250	N3	Subscriber Address	O	1			Situational
0300	N4	Subscriber City, State, ZIP Code	O	1			Required
0320	DMG	Subscriber Demographic Information	O	1			Situational
0350	REF	Subscriber Secondary Identification	O	1			Situational
0350	REF	Property and Casualty Claim Number	O	1			Situational

LOOP ID - 2010BB					1	N2/0150L	
0150	NM1	Payer Name	O	1		N2/0150	Required
0250	N3	Payer Address	O	1			Situational
0300	N4	Payer City, State, ZIP Code	O	1			Required
0350	REF	Payer Secondary Identification	O	3			Situational
0350	REF	Billing Provider Secondary Identification	O	1			Situational

LOOP ID - 2300					100		
1300	CLM	Claim information	O	1			Situational
1350	DTP	Discharge Hour	O	1			Situational
1350	DTP	Statement Dates	O	1			Required
1350	DTP	Admission Date/Hour	O	1			Situational
1350	DTP	Date - Repricer Received Date	O	1			Situational
1400	CL1	Institutional Claim Code	O	1			Required
1550	PWK	Claim Supplemental Information	O	10			Situational
1600	CN1	Contract Information	O	1			Situational
1750	AMT	Patient Estimated Amount Due	O	1			Situational
1800	REF	Service Authorization Exception Code	O	1			Situational
1800	REF	Referral Number	O	1			Situational
1800	REF	Prior Authorization	O	1			Situational
1800	REF	Payer Claim Control Number	O	1			Situational
1800	REF	Repriced Claim Number	O	1			Situational
1800	REF	Adjusted Repriced Claim Number	O	1			Situational

1800	REF	Investigational Device Exemption Number	O	5			Situational
1800	REF	Claim Identifier For Transmission Intermediaries	O	1			Situational
1800	REF	Auto Accident State	O	1			Situational
1800	REF	Medical Record Number	O	1			Situational
1800	REF	Demonstration Project Identifier	O	1			Situational
1800	REF	Peer Review Organization (PRO) Approval Number	O	1			Situational
1850	K3	File Information	O	10			Situational
1900	NTE	Claim Note	O	10			Situational
1900	NTE	Billing Note	O	1			Situational
2200	CRC	EPSDT Referral	O	1			Situational
2310	HI	Principal Diagnosis	O	1			Required
2310	HI	Admitting Diagnosis	O	1			Situational
2310	HI	Patient's Reason For Visit	O	1			Situational
2310	HI	External Cause of Injury	O	1			Situational
2310	HI	Diagnosis Related Group (DRG) Information	O	1			Situational
2310	HI	Other Diagnosis Information	O	2			Situational
2310	HI	Principal Procedure Information	O	1			Situational
2310	HI	Other Procedure Information	O	2			Situational
2310	HI	Occurrence Span Information	O	2			Situational
2310	HI	Occurrence Information	O	2			Situational
2310	HI	Value Information	O	2			Situational
2310	HI	Condition Information	O	2			Situational
2310	HI	Treatment Code Information	O	2			Situational
2410	HCP	Claim Pricing/Repricing Information	O	1			Situational
LOOP ID - 2310A					**1**	**N2/2500L**	
2500	NM1	Attending Provider Name	O	1		N2/2500	Situational
2550	PRV	Attending Provider Specialty Information	O	1			Situational
2710	REF	Attending Provider Secondary Identification	O	4			Situational
LOOP ID - 2310B					**1**	**N2/2500L**	
2500	NM1	Operating Physician Name	O	1		N2/2500	Situational
2710	REF	Operating Physician Secondary Identification	O	4			Situational
LOOP ID - 2310C					**1**	**N2/2500L**	
2500	NM1	Other Operating Physician Name	O	1		N2/2500	Situational
2710	REF	Other Operating Physician Secondary Identification	O	4			Situational
LOOP ID - 2310D					**1**	**N2/2500L**	
2500	NM1	Rendering Provider Name	O	1		N2/2500	Situational
2710	REF	Rendering Provider Secondary Identification	O	4			Situational
LOOP ID - 2310E					**1**	**N2/2500L**	
2500	NM1	Service Facility Location	O	1		N2/2500	Situational

		Name					
2650	N3	Service Facility Location Address	O	1			Required
2700	N4	Service Facility Location City/State/ZIP	O	1			Required
2710	REF	Service Facility Secondary Identification	O	3			Situational
LOOP ID - 2310F					**1**	**N2/2500L**	
2500	NM1	Referring Provider Name	O	1		N2/2500	Situational
2710	REF	Referring Provider Secondary Identification	O	3			Situational
LOOP ID - 2320					**10**	**N2/2900L**	
2900	SBR	Other Subscriber Information	O	1		N2/2900	Situational
2950	CAS	Claim Level Adjustments	O	5			Situational
3000	AMT	Coordination of Benefits (COB) Payer Paid Amount	O	1			Situational
3000	AMT	Remaining Patient Liability	O	1			Situational
3000	AMT	Coordination of Benefits (COB) Total Non-covered Amount	O	1			Situational
3100	OI	Other Insurance Coverage Information	O	1			Required
3150	MIA	Inpatient Adjudication Information	O	1			Situational
3200	MOA	Outpatient Adjudication Information	O	1			Situational
LOOP ID - 2330A					**1**	**N2/3250L**	
3250	NM1	Other Subscriber Name	O	1		N2/3250	Required
3320	N3	Other Subscriber Address	O	1			Situational
3400	N4	Other Subscriber City/State/ZIP Code	O	1			Required
3550	REF	Other Subscriber Secondary Information	O	2			Situational
LOOP ID - 2330B					**1**	**N2/3250L**	
3250	NM1	Other Payer Name	O	1		N2/3250	Required
3320	N3	Other Payer Address	O	1			Situational
3400	N4	Other Payer City/State/ZIP Code	O	1			Required
3500	DTP	Claim Check Or Remittance Date	O	1			Situational
3550	REF	Other Payer Secondary Identifier	O	2			Situational
3550	REF	Other Payer Prior Authorization Number	O	1			Situational
3550	REF	Other Payer Referral Number	O	2			Situational
3550	REF	Other Payer Claim Adjustment Indicator	O	1			Situational
3550	REF	Other Payer Claim Control Number	O	1			Situational
LOOP ID - 2330C					**1**	**N2/3250L**	
3250	NM1	Other Payer Attending Provider	O	1		N2/3250	Situational
3550	REF	Other Payer Attending	O	4			Required

		Provider Secondary Identification					
LOOP ID - 2330D					**1**	**N2/3250L**	
3250	NM1	Other Payer Operating Physician	O	1		N2/3250	Situational
3550	REF	Other Payer Operating Physician Secondary Identification	O	4			Required
LOOP ID - 2330E					**1**	**N2/3250L**	
3250	NM1	Other Payer Other Operating Physician	O	1		N2/3250	Situational
3550	REF	Other Payer Other Operating Physician Secondary Identification	O	4			Required
LOOP ID - 2330F					**1**	**N2/3250L**	
3250	NM1	Other Payer Service Facility Location	O	1		N2/3250	Situational
3550	REF	Other Payer Service Facility Location Secondary Identification	O	3			Required
LOOP ID - 2330G					**1**	**N2/3250L**	
3250	NM1	Other Payer Rendering Provider Name	O	1		N2/3250	Situational
3550	REF	Other Payer Rendering Provider Secondary Identifier	O	4			Required
LOOP ID - 2330H					**1**	**N2/3250L**	
3250	NM1	Other Payer Referring Provider	O	1		N2/3250	Situational
3550	REF	Other Payer Referring Provider Secondary Identification	O	3			Required
LOOP ID - 2330I					**1**	**N2/3250L**	
3250	NM1	Other Payer Billing Provider	O	1		N2/3250	Situational
3550	REF	Other Payer Billing Provider Secondary Identifier	O	2			Required
LOOP ID - 2400					**999**	**N2/3650L**	
3650	LX	Service Line Number	O	1		N2/3650	Required
3750	SV2	Institutional Service Line	O	1			Required
4200	PWK	Line Supplemental Information	O	10			Situational
4550	DTP	Date - Service Date	O	1			Situational
4700	REF	Line Item Control Number	O	1			Situational
4700	REF	Repriced Line Item Reference Number	O	1			Situational
4700	REF	Adjusted Repriced Line Item Reference Number	O	1			Situational
4750	AMT	Service Tax Amount	O	1			Situational
4750	AMT	Facility Tax Amount	O	1			Situational
4850	NTE	Third Party Organization Notes	O	1			Situational
4920	HCP	Line Pricing/Repricing Information	O	1			Situational

LOOP ID - 2410					1	N2/4930L	
4930	LIN	Drug Identification	O	1		N2/4930	Situational
4940	CTP	Drug Quantity	O	1			Required
4950	REF	Prescription or Compound Drug Association Number	O	1			Situational

LOOP ID - 2420A					1	N2/5000L	
5000	NM1	Operating Physician Name	O	1		N2/5000	Situational
5250	REF	Operating Physician Secondary Identification	O	20			Situational

LOOP ID - 2420B					1	N2/5000L	
5000	NM1	Other Operating Physician Name	O	1		N2/5000	Situational
5250	REF	Other Operating Physician Secondary Identification	O	20			Situational

LOOP ID - 2420C					1	N2/5000L	
5000	NM1	Rendering Provider Name	O	1		N2/5000	Situational
5250	REF	Rendering Provider Secondary Identification	O	20			Situational

LOOP ID - 2420D					1	N2/5000L	
5000	NM1	Referring Provider Name	O	1		N2/5000	Situational
5250	REF	Referring Provider Secondary Identification	O	20			Situational

LOOP ID - 2430					15	N2/5400L	
5400	SVD	Line Adjudication Information	O	1		N2/5400	Situational
5450	CAS	Line Adjustment	O	5			Situational
5500	DTP	Line Check or Remittance Date	O	1			Required
5505	AMT	Remaining Patient Liability	O	1			Situational

LOOP ID - 2000C					>1		
0010	HL	Patient Hierarchical Level	O	1			Situational
0070	PAT	Patient Information	O	1			Required
LOOP ID - 2010CA					**1**	**N2/0150L**	
0150	NM1	Patient Name	O	1		N2/0150	Required
0250	N3	Patient Address	O	1			Required
0300	N4	Patient City/State/ZIP Code	O	1			Required
0320	DMG	Patient Demographic Information	O	1			Required
0350	REF	Property and Casualty Claim Number	O	1			Situational

LOOP ID - 2300					100		
1300	CLM	Claim information	O	1			Required
1350	DTP	Discharge Hour	O	1			Situational
1350	DTP	Statement Dates	O	1			Required
1350	DTP	Admission Date/Hour	O	1			Situational
1350	DTP	Date - Repricer Received Date	O	1			Situational
1400	CL1	Institutional Claim Code	O	1			Required
1550	PWK	Claim Supplemental Information	O	10			Situational
1600	CN1	Contract Information	O	1			Situational
1750	AMT	Patient Estimated Amount	O	1			Situational

		Due					
1800	REF	Service Authorization Exception Code	O	1			Situational
1800	REF	Referral Number	O	1			Situational
1800	REF	Prior Authorization	O	1			Situational
1800	REF	Payer Claim Control Number	O	1			Situational
1800	REF	Repriced Claim Number	O	1			Situational
1800	REF	Adjusted Repriced Claim Number	O	1			Situational
1800	REF	Investigational Device Exemption Number	O	5			Situational
1800	REF	Claim Identifier For Transmission Intermediaries	O	1			Situational
1800	REF	Auto Accident State	O	1			Situational
1800	REF	Medical Record Number	O	1			Situational
1800	REF	Demonstration Project Identifier	O	1			Situational
1800	REF	Peer Review Organization (PRO) Approval Number	O	1			Situational
1850	K3	File Information	O	10			Situational
1900	NTE	Claim Note	O	10			Situational
1900	NTE	Billing Note	O	1			Situational
2200	CRC	EPSDT Referral	O	1			Situational
2310	HI	Principal Diagnosis	O	1			Required
2310	HI	Admitting Diagnosis	O	1			Situational
2310	HI	Patient's Reason For Visit	O	1			Situational
2310	HI	External Cause of Injury	O	1			Situational
2310	HI	Diagnosis Related Group (DRG) Information	O	1			Situational
2310	HI	Other Diagnosis Information	O	2			Situational
2310	HI	Principal Procedure Information	O	1			Situational
2310	HI	Other Procedure Information	O	2			Situational
2310	HI	Occurrence Span Information	O	2			Situational
2310	HI	Occurrence Information	O	2			Situational
2310	HI	Value Information	O	2			Situational
2310	HI	Condition Information	O	2			Situational
2310	HI	Treatment Code Information	O	2			Situational
2410	HCP	Claim Pricing/Repricing Information	O	1			Situational
LOOP ID - 2310A					**1**	**N2/2500L**	
2500	NM1	Attending Provider Name	O	1		N2/2500	Situational
2550	PRV	Attending Provider Specialty Information	O	1			Situational
2710	REF	Attending Provider Secondary Identification	O	4			Situational
LOOP ID - 2310B					**1**	**N2/2500L**	
2500	NM1	Operating Physician Name	O	1		N2/2500	Situational
2710	REF	Operating Physician Secondary Identification	O	4			Situational
LOOP ID - 2310C					**1**	**N2/2500L**	
2500	NM1	Other Operating Physician	O	1		N2/2500	Situational

		Name					
2710	REF	Other Operating Physician Secondary Identification	O	4			Situational
LOOP ID - 2310D					**1**	**N2/2500L**	
2500	NM1	Rendering Provider Name	O	1		N2/2500	Situational
2710	REF	Rendering Provider Secondary Identification	O	4			Situational
LOOP ID - 2310E					**1**	**N2/2500L**	
2500	NM1	Service Facility Location Name	O	1		N2/2500	Situational
2650	N3	Service Facility Location Address	O	1			Required
2700	N4	Service Facility Location City/State/ZIP	O	1			Required
2710	REF	Service Facility Secondary Identification	O	3			Situational
LOOP ID - 2310F					**1**	**N2/2500L**	
2500	NM1	Referring Provider Name	O	1		N2/2500	Situational
2710	REF	Referring Provider Secondary Identification	O	3			Situational
LOOP ID - 2320					**10**	**N2/2900L**	
2900	SBR	Other Subscriber Information	O	1		N2/2900	Situational
2950	CAS	Claim Level Adjustments	O	5			Situational
3000	AMT	Coordination of Benefits (COB) Payer Paid Amount	O	1			Situational
3000	AMT	Remaining Patient Liability	O	1			Situational
3000	AMT	Coordination of Benefits (COB) Total Non-covered Amount	O	1			Situational
3100	OI	Other Insurance Coverage Information	O	1			Required
3150	MIA	Inpatient Adjudication Information	O	1			Situational
3200	MOA	Outpatient Adjudication Information	O	1			Situational
LOOP ID - 2330A					**1**	**N2/3250L**	
3250	NM1	Other Subscriber Name	O	1		N2/3250	Required
3320	N3	Other Subscriber Address	O	1			Situational
3400	N4	Other Subscriber City/State/ZIP Code	O	1			Required
3550	REF	Other Subscriber Secondary Information	O	2			Situational
LOOP ID - 2330B					**1**	**N2/3250L**	
3250	NM1	Other Payer Name	O	1		N2/3250	Required
3320	N3	Other Payer Address	O	1			Situational
3400	N4	Other Payer City/State/ZIP Code	O	1			Required
3500	DTP	Claim Check Or Remittance Date	O	1			Situational
3550	REF	Other Payer Secondary Identifier	O	2			Situational
3550	REF	Other Payer Prior Authorization Number	O	1			Situational

3550	REF	Other Payer Referral Number	O	2			Situational
3550	REF	Other Payer Claim Adjustment Indicator	O	1			Situational
3550	REF	Other Payer Claim Control Number	O	1			Situational
LOOP ID - 2330C					**1**	**N2/3250L**	
3250	NM1	Other Payer Attending Provider	O	1		N2/3250	Situational
3550	REF	Other Payer Attending Provider Secondary Identification	O	4			Required
LOOP ID - 2330D					**1**	**N2/3250L**	
3250	NM1	Other Payer Operating Physician	O	1		N2/3250	Situational
3550	REF	Other Payer Operating Physician Secondary Identification	O	4			Required
LOOP ID - 2330E					**1**	**N2/3250L**	
3250	NM1	Other Payer Other Operating Physician	O	1		N2/3250	Situational
3550	REF	Other Payer Other Operating Physician Secondary Identification	O	4			Required
LOOP ID - 2330F					**1**	**N2/3250L**	
3250	NM1	Other Payer Service Facility Location	O	1		N2/3250	Situational
3550	REF	Other Payer Service Facility Location Secondary Identification	O	3			Required
LOOP ID - 2330G					**1**	**N2/3250L**	
3250	NM1	Other Payer Rendering Provider Name	O	1		N2/3250	Situational
3550	REF	Other Payer Rendering Provider Secondary Identifier	O	4			Required
LOOP ID - 2330H					**1**	**N2/3250L**	
3250	NM1	Other Payer Referring Provider	O	1		N2/3250	Situational
3550	REF	Other Payer Referring Provider Secondary Identification	O	3			Required
LOOP ID - 2330I					**1**	**N2/3250L**	
3250	NM1	Other Payer Billing Provider	O	1		N2/3250	Situational
3550	REF	Other Payer Billing Provider Secondary Identifier	O	2			Required
LOOP ID - 2400					**999**	**N2/3650L**	
3650	LX	Service Line Number	O	1		N2/3650	Required
3750	SV2	Institutional Service Line	O	1			Required
4200	PWK	Line Supplemental Information	O	10			Situational
4550	DTP	Date - Service Date	O	1			Situational
4700	REF	Line Item Control Number	O	1			Situational

4700	REF	Repriced Line Item Reference Number	O	1			Situational
4700	REF	Adjusted Repriced Line Item Reference Number	O	1			Situational
4750	AMT	Service Tax Amount	O	1			Situational
4750	AMT	Facility Tax Amount	O	1			Situational
4850	NTE	Third Party Organization Notes	O	1			Situational
4920	HCP	Line Pricing/Repricing Information	O	1			Situational
LOOP ID - 2410					**1**	**N2/4930L**	
4930	LIN	Drug Identification	O	1		N2/4930	Situational
4940	CTP	Drug Quantity	O	1			Required
4950	REF	Prescription or Compound Drug Association Number	O	1			Situational
LOOP ID - 2420A					**1**	**N2/5000L**	
5000	NM1	Operating Physician Name	O	1		N2/5000	Situational
5250	REF	Operating Physician Secondary Identification	O	20			Situational
LOOP ID - 2420B					**1**	**N2/5000L**	
5000	NM1	Other Operating Physician Name	O	1		N2/5000	Situational
5250	REF	Other Operating Physician Secondary Identification	O	20			Situational
LOOP ID - 2420C					**1**	**N2/5000L**	
5000	NM1	Rendering Provider Name	O	1		N2/5000	Situational
5250	REF	Rendering Provider Secondary Identification	O	20			Situational
LOOP ID - 2420D					**1**	**N2/5000L**	
5000	NM1	Referring Provider Name	O	1		N2/5000	Situational
5250	REF	Referring Provider Secondary Identification	O	20			Situational
LOOP ID - 2430					**15**	**N2/5400L**	
5400	SVD	Line Adjudication Information	O	1		N2/5400	Situational
5450	CAS	Line Adjustment	O	5			Situational
5500	DTP	Line Check or Remittance Date	O	1			Required
5505	AMT	Remaining Patient Liability	O	1			Situational
5550	SE	Transaction Set Trailer	M	1			Required

PRV Billing Provider Specialty Information

Pos: 0030	Max: 1
Detail - Optional	
Loop: 2000A	Elements: 3

User Option (Usage): Situational
Purpose: To specify the identifying characteristics of a provider

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
PRV01	1221	**Provider Code**	M	ID	1/3	Required
		Description: Code identifying the type of provider				
PRV02	128	**Reference Identification Qualifier**	X	ID	2/3	Required
		Description: Code qualifying the Reference Identification				
PRV03	127	**Reference Identification**	X	AN	1/50	Required
		Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier				

Encounter Notes:

Error Message: BILLING/PAY-TO PROVIDER MISSING - Loop Required by TennCare (2000A 837I)

Detail: PRV segment in Loop 2000A will be required.

NM1 Billing Provider Name

Pos: 0150	Max: 1
Detail - Optional	
Loop: 2010AA	Elements: 5

User Option (Usage): Required
Purpose: To supply the full name of an individual or organizational entity

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
NM101	98	**Entity Identifier Code**	M	ID	2/3	Required
		Description: Code identifying an organizational entity, a physical location, property or an individual				
NM102	1065	**Entity Type Qualifier**	M	ID	1/1	Required
		Description: Code qualifying the type of entity				
NM103	1035	**Name Last or Organization Name**	X	AN	1/60	Required
		Description: Individual last name or organizational name				
NM108	66	**Identification Code Qualifier**	X	ID	1/2	Situational
		Description: Code designating the system/method of code structure used for Identification Code (67)				
NM109	67	**Identification Code**	X	AN	2/80	Situational
		Description: Code identifying a party or other code				

Encounter Notes: *Error Message: NPI MUST BE THE BILLING PROVIDER PRIMARY IDENTIFIER.*

Detail: Excludes denied claims with ARC 107. If the Billing Provider is a HealthCare provider (not atypical), If 2010AA NM108 value is = XX and the 2010AA NM109 value is not 10 digits or does not contain a correct check digit, set edit. An atypical provider is identified by the taxonomy code in 2000/PRV03 where PRV01=BI and is defined as any on the taxonomy listing provided by TennCare in the "Taxonomy Codes with healthcare provider Indicator 20071016" document. These are defined by TennCare as healthcare providers and non-healthcare providers (the N values are Atypical).

NM1 Payer Name

Pos: 0150	Max: 1
Detail - Optional	
Loop: 2010BB	Elements: 5

User Option (Usage): Required
Purpose: To supply the full name of an individual or organizational entity

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
NM101	98	**Entity Identifier Code**	M	ID	2/3	Required
		Description: Code identifying an organizational entity, a physical location, property or an individual				
NM102	1065	**Entity Type Qualifier**	M	ID	1/1	Required
		Description: Code qualifying the type of entity				
NM103	1035	**Name Last or Organization Name**	X	AN	1/60	Required
		Description: Individual last name or organizational name				
NM108	66	**Identification Code Qualifier**	X	ID	1/2	Required
		Description: Code designating the system/method of code structure used for Identification Code (67)				
NM109	67	**Identification Code**	X	AN	2/80	Required
		Description: Code identifying a party or other code **Encounter Notes:** *Error Message: PAYER NAME IDENTIFICATION NUMBER INVALID - TennCare Required ID Number Is Missing (837I, 2010BC/NM109).* *Detail: If (837I: 2010BC/NM109 where NM101=PR) != 626001445, then set edit.*				

CLM Claim information

Pos: 1300	Max: 1
Detail - Optional	
Loop: 2300	Elements: 7

User Option (Usage): Situational
Purpose: To specify basic data about the claim

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
CLM01	1028	**Claim Submitter's Identifier**	M	AN	1/38	Required
		Description: Identifier used to track a claim from creation by the health care provider through payment				
CLM02	782	**Monetary Amount**	O	R	1/18	Required
		Description: Monetary amount				
CLM05	C023	**Health Care Service Location Information**	O	Comp		Required
		Description: To provide information that identifies the place of service or the type of bill related to the location at which a health care service was rendered				
CLM05-01	1331	**Facility Code Value**	M	AN	1/2	Required
		Description: Code identifying where services were, or may be, performed; the first and second positions of the Uniform Bill Type Code for Institutional Services or the Place of Service Codes for Professional or Dental Services.				
CLM05-02	1332	**Facility Code Qualifier**	O	ID	1/2	Required
		Description: Code identifying the type of facility referenced				
CLM05-03	1325	**Claim Frequency Type Code**	O	ID	1/1	Required
		Description: Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type **Encounter Notes:** *Error Message: CLAIM FREQUENCY CODE 7 IS NOT ALLOWED - Replacement Encounter Claims Are Not Processed By TennCare (2300/CLM05-3).* *Detail: If 2300/CLM05-3 is equal to "7", then error.*				
CLM07	1359	**Provider Accept Assignment Code**	O	ID	1/1	Required
		Description: Code indicating whether the provider accepts assignment				
CLM08	1073	**Yes/No Condition or Response Code**	O	ID	1/1	Required
		Description: Code indicating a Yes or No condition or response				
CLM09	1363	**Release of Information Code**	O	ID	1/1	Required
		Description: Code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations				
CLM20	1514	**Delay Reason Code**	O	ID	1/2	Situational
		Description: Code indicating the reason why a request was delayed				

DTP Statement Dates

Pos: 1350	Max: 1
Detail - Optional	
Loop: 2300	Elements: 3

User Option (Usage): Required
Purpose: To specify any or all of a date, a time, or a time period

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
DTP01	374	**Date/Time Qualifier**	M	ID	3/3	Required
		Description: Code specifying type of date or time, or both date and time				
DTP02	1250	**Date Time Period Format Qualifier**	M	ID	2/3	Required
		Description: Code indicating the date format, time format, or date and time format				
DTP03	1251	**Date Time Period**	M	AN	1/35	Required
		Description: Expression of a date, a time, or range of dates, times or dates and times				

Encounter Notes: *Error Message: DATE OF SERVICE CANNOT BE BEFORE DATE OF BIRTH - All services must take place on or after the date of birth (2010CA/DMG02 or 2010BA/DMG02)*

Detail: Excludes denied claims with ARC 107. Date of service = 2300/DTP03 [837I: 2300/DTP03 (DTP01=434)], date of birth = 2010BA/DMG02 or 2010CA/DMG02. Error if date of birth is after date of service. All services must take place on or after the date of birth.

Error Message: HEADER SERVICE DATE MUST BE WITHIN DETAIL SERVICE DATES - The detail level dates if used must be within the range of the header dates.

Detail: Excludes denied claims with ARC 107. Check if 2400/DTP03 are within 2300/DTP03. This is a claim level edit. The detail level dates, if used, must be within the range of the header dates. If the claim service date is > the detail service date on the claim, an error will be reported. The dates are found in 2300/DTP03 (837I: DTP01=434).

Error Message: ENCOUNTER DATE OF SERVICE CANNOT BE GREATER THAN MCC RECEIPT DATE (2300/K301).

*Detail: The edit applies to both dates in the 837I. If any service date (837I: 2300/DTP03 where DTP01=434 or 837I: 2400/DTP03 where DTP01=472) is greater than the MCC Receipt Date (2300/K301), then that service date is in error. The DTP02 should be inspected and if the DTP02=RD8, then the Begin date (the first date in the date range) should be used for comparing against the Receipt Date. For example, if the DTP segment looked like "DTP*472*RD8*20060911-20060922" the Service date would be "20060911".*

REF Payer Claim Control Number

Pos: 1800	Max: 1
Detail - Optional	
Loop: 2300	Elements: 2

User Option (Usage): Situational
Purpose: To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF01	128	**Reference Identification Qualifier**	M	ID	2/3	Required
		Description: Code qualifying the Reference Identification				
REF02	127	**Reference Identification**	X	AN	1/50	Required
		Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier				
		Encounter Notes: *Error Message: REQUIRED ORIGINAL REFERENCE NUMBER MISSING - TennCare Requires a Voided Claim (CLM05-3 = 8) To Be Submitted With The Original Claim Number (REF02 when REF01= F8).* *Detail: If 2300/CLM05-3 = 8 and if no data in 2300/REF02 where REF01=F8, then set edit. If 2300/REF01=F8 segment is missing, set the edit.*				

K3 File Information

Pos: 1850	Max: 10
Detail - Optional	
Loop: 2300	Elements: 1

User Option (Usage): Situational
Purpose: To transmit a fixed-format record or matrix contents

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
K301	449	**Fixed Format Information**	M	AN	1/80	Required

Description: Data in fixed format agreed upon by sender and receiver
Encounter Notes: *Error Message: ENCOUNTER DATE OF RECEIPT IS MISSING - TennCare Requires A Valid MCC Encounter Receipt Date (2300/K301). Valid format CCYYMMDD.*

Detail: Edit should be applied to the 2300/K301 only. The edit should verify that the MCC Receipt Date (2300/K301) exists (MUST BE USED) and well formatted (Lexical format CCYYMMDD).

NTE Billing Note

Pos: 1900	Max: 1
Detail - Optional	
Loop: 2300	Elements: 2

User Option (Usage): Situational
Purpose: To transmit information in a free-form format, if necessary, for comment or special instruction

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
NTE01	363	**Note Reference Code**	O	ID	3/3	Required
		Description: Code identifying the functional area or purpose for which the note applies				
NTE02	352	**Description**	M	AN	1/80	Required
		Description: A free-form description to clarify the related data elements and their content				

Encounter Notes: *Error Message: REQUIRED CLAIM SEQUENCE NUMBER MISSING - TennCare sequencer is defined as the first subcomponent (NTE02-1) of the 2300 NTE02 where the NTE01 = ADD.*

Detail: 2300 NTE02 is Required for TennCare. The ONLY allowed NTE01 qualifier is 'ADD'. HIPAA defined standard element of length 80. The edit parses the NTE02 when NTE01 = "ADD", from the beginning of the element until either the segment terminator or the pipe symbol "|" is encountered. If the pipe symbol is encountered, all bytes following it until the segment terminator are the claim note and all bytes prior to the pipe are to be considered the Processing Sequence Identifier. If no pipe is found then the entire contents are considered Processing Sequence Identifier (80 bytes).This is a SNIP 1 error. The SNIP 7 error will set when the NTE02 is missing.

HI Occurrence Span Information

Pos: 2310	Max: 2
Detail - Optional	
Loop: 2300	Elements: 12

User Option (Usage): Situational
Purpose: To supply information related to the delivery of health care

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
HI01	C022	**Health Care Code Information**	M	Comp		Required
		Description: To send health care codes and their associated dates, amounts and quantities				
HI01-01	1270	**Code List Qualifier Code**	M	ID	1/3	Required
		Description: Code identifying a specific industry code list				
HI01-02	1271	**Industry Code**	M	AN	1/30	Required
		Description: Code indicating a code from a specific industry code list				
HI01-03	1250	**Date Time Period Format Qualifier**	X	ID	2/3	Required
		Description: Code indicating the date format, time format, or date and time format				
HI01-04	1251	**Date Time Period**	X	AN	1/35	Required
		Description: Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** *Error Message: THE FROM DATE CANNOT BE AFTER THE TO DATE FOR OCCURRENCE SPAN CODES 1-12.* *Detail: Excludes denied claims with ARC 107. Occurrence span date = HI (01-12)-4 where HI(01-12)-1 = BI. If "FROM" date > "TO" date, then set edit.*				
HI02	C022	**Health Care Code Information**	O	Comp		Situational
		Description: To send health care codes and their associated dates, amounts and quantities				
HI02-01	1270	**Code List Qualifier Code**	M	ID	1/3	Required
		Description: Code identifying a specific industry code list				
HI02-02	1271	**Industry Code**	M	AN	1/30	Required
		Description: Code indicating a code from a specific industry code list				
HI02-03	1250	**Date Time Period Format Qualifier**	X	ID	2/3	Required
		Description: Code indicating the date format, time format, or date and time format				
HI02-04	1251	**Date Time Period**	X	AN	1/35	Required
		Description: Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** *Error Message: THE FROM DATE CANNOT BE AFTER THE TO DATE FOR OCCURRENCE SPAN CODES 1-12.* *Detail: Excludes denied claims with ARC 107. Occurrence span date = HI (01-12)-4 where HI(01-12)-1 = BI. If "FROM" date > "TO" date, then set edit.*				
HI03	C022	**Health Care Code Information**	O	Comp		Situational
		Description: To send health care codes and their associated dates, amounts and quantities				
HI03-01	1270	**Code List Qualifier Code**	M	ID	1/3	Required
		Description: Code identifying a specific industry code list				
HI03-02	1271	**Industry Code**	M	AN	1/30	Required
		Description: Code indicating a code from a specific industry code list				

HI03-03	1250	**Date Time Period Format Qualifier**	X	ID	2/3	Required
		Description: Code indicating the date format, time format, or date and time format				
HI03-04	1251	**Date Time Period**	X	AN	1/35	Required
		Description: Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** *Error Message: THE FROM DATE CANNOT BE AFTER THE TO DATE FOR OCCURRENCE SPAN CODES 1-12.* *Detail: Excludes denied claims with ARC 107. Occurrence span date = HI (01-12)-4 where HI(01-12)-1 = BI. If "FROM" date > "TO" date, then set edit.*				
HI04	C022	**Health Care Code Information**	O	Comp		Situational
		Description: To send health care codes and their associated dates, amounts and quantities				
HI04-01	1270	**Code List Qualifier Code**	M	ID	1/3	Required
		Description: Code identifying a specific industry code list				
HI04-02	1271	**Industry Code**	M	AN	1/30	Required
		Description: Code indicating a code from a specific industry code list				
HI04-03	1250	**Date Time Period Format Qualifier**	X	ID	2/3	Required
		Description: Code indicating the date format, time format, or date and time format				
HI04-04	1251	**Date Time Period**	X	AN	1/35	Required
		Description: Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** *Error Message: THE FROM DATE CANNOT BE AFTER THE TO DATE FOR OCCURRENCE SPAN CODES 1-12.* *Detail: Excludes denied claims with ARC 107. Occurrence span date = HI (01-12)-4 where HI(01-12)-1 = BI. If "FROM" date > "TO" date, then set edit.*				
HI05	C022	**Health Care Code Information**	O	Comp		Situational
		Description: To send health care codes and their associated dates, amounts and quantities				
HI05-01	1270	**Code List Qualifier Code**	M	ID	1/3	Required
		Description: Code identifying a specific industry code list				
HI05-02	1271	**Industry Code**	M	AN	1/30	Required
		Description: Code indicating a code from a specific industry code list				
HI05-03	1250	**Date Time Period Format Qualifier**	X	ID	2/3	Required
		Description: Code indicating the date format, time format, or date and time format				
HI05-04	1251	**Date Time Period**	X	AN	1/35	Required
		Description: Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** *Error Message: THE FROM DATE CANNOT BE AFTER THE TO DATE FOR OCCURRENCE SPAN CODES 1-12.* *Detail: Excludes denied claims with ARC 107. Occurrence span date = HI (01-12)-4 where HI(01-12)-1 = BI. If "FROM" date > "TO" date, then set edit.*				
HI06	C022	**Health Care Code Information**	O	Comp		Situational
		Description: To send health care codes and their associated dates, amounts and quantities				
HI06-01	1270	**Code List Qualifier Code**	M	ID	1/3	Required
		Description: Code identifying a specific industry code list				
HI06-02	1271	**Industry Code**	M	AN	1/30	Required
		Description: Code indicating a code from a specific industry code list				

HI06-03	1250	**Date Time Period Format Qualifier**	X	ID	2/3	Required
		Description: Code indicating the date format, time format, or date and time format				
HI06-04	1251	**Date Time Period**	X	AN	1/35	Required
		Description: Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** *Error Message: THE FROM DATE CANNOT BE AFTER THE TO DATE FOR OCCURRENCE SPAN CODES 1-12.* *Detail: Excludes denied claims with ARC 107. Occurrence span date = HI (01-12)-4 where HI(01-12)-1 = BI. If "FROM" date > "TO" date, then set edit.*				
HI07	C022	**Health Care Code Information**	O	Comp		Situational
		Description: To send health care codes and their associated dates, amounts and quantities				
HI07-01	1270	**Code List Qualifier Code**	M	ID	1/3	Required
		Description: Code identifying a specific industry code list				
HI07-02	1271	**Industry Code**	M	AN	1/30	Required
		Description: Code indicating a code from a specific industry code list				
HI07-03	1250	**Date Time Period Format Qualifier**	X	ID	2/3	Required
		Description: Code indicating the date format, time format, or date and time format				
HI07-04	1251	**Date Time Period**	X	AN	1/35	Required
		Description: Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** *Error Message: THE FROM DATE CANNOT BE AFTER THE TO DATE FOR OCCURRENCE SPAN CODES 1-12.* *Detail: Excludes denied claims with ARC 107. Occurrence span date = HI (01-12)-4 where HI(01-12)-1 = BI. If "FROM" date > "TO" date, then set edit.*				
HI08	C022	**Health Care Code Information**	O	Comp		Situational
		Description: To send health care codes and their associated dates, amounts and quantities				
HI08-01	1270	**Code List Qualifier Code**	M	ID	1/3	Required
		Description: Code identifying a specific industry code list				
HI08-02	1271	**Industry Code**	M	AN	1/30	Required
		Description: Code indicating a code from a specific industry code list				
HI08-03	1250	**Date Time Period Format Qualifier**	X	ID	2/3	Required
		Description: Code indicating the date format, time format, or date and time format				
HI08-04	1251	**Date Time Period**	X	AN	1/35	Required
		Description: Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** *Error Message: THE FROM DATE CANNOT BE AFTER THE TO DATE FOR OCCURRENCE SPAN CODES 1-12.* *Detail: Excludes denied claims with ARC 107. Occurrence span date = HI (01-12)-4 where HI(01-12)-1 = BI. If "FROM" date > "TO" date, then set edit.*				
HI09	C022	**Health Care Code Information**	O	Comp		Situational
		Description: To send health care codes and their associated dates, amounts and quantities				
HI09-01	1270	**Code List Qualifier Code**	M	ID	1/3	Required
		Description: Code identifying a specific industry code list				
HI09-02	1271	**Industry Code**	M	AN	1/30	Required

		Description: Code indicating a code from a specific industry code list				
HI09-03	1250	**Date Time Period Format Qualifier**	X	ID	2/3	Required
		Description: Code indicating the date format, time format, or date and time format				
HI09-04	1251	**Date Time Period**	X	AN	1/35	Required
		Description: Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** *Error Message: THE FROM DATE CANNOT BE AFTER THE TO DATE FOR OCCURRENCE SPAN CODES 1-12.* *Detail: Excludes denied claims with ARC 107. Occurrence span date = HI (01-12)-4 where HI(01-12)-1 = BI. If "FROM" date > "TO" date, then set edit.*				
HI10	C022	**Health Care Code Information**	O	Comp		Situational
		Description: To send health care codes and their associated dates, amounts and quantities				
HI10-01	1270	**Code List Qualifier Code**	M	ID	1/3	Required
		Description: Code identifying a specific industry code list				
HI10-02	1271	**Industry Code**	M	AN	1/30	Required
		Description: Code indicating a code from a specific industry code list				
HI10-03	1250	**Date Time Period Format Qualifier**	X	ID	2/3	Required
		Description: Code indicating the date format, time format, or date and time format				
HI10-04	1251	**Date Time Period**	X	AN	1/35	Required
		Description: Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** *Error Message: THE FROM DATE CANNOT BE AFTER THE TO DATE FOR OCCURRENCE SPAN CODES 1-12.* *Detail: Excludes denied claims with ARC 107. Occurrence span date = HI (01-12)-4 where HI(01-12)-1 = BI. If "FROM" date > "TO" date, then set edit.*				
HI11	C022	**Health Care Code Information**	O	Comp		Situational
		Description: To send health care codes and their associated dates, amounts and quantities				
HI11-01	1270	**Code List Qualifier Code**	M	ID	1/3	Required
		Description: Code identifying a specific industry code list				
HI11-02	1271	**Industry Code**	M	AN	1/30	Required
		Description: Code indicating a code from a specific industry code list				
HI11-03	1250	**Date Time Period Format Qualifier**	X	ID	2/3	Required
		Description: Code indicating the date format, time format, or date and time format				
HI11-04	1251	**Date Time Period**	X	AN	1/35	Required
		Description: Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** *Error Message: THE FROM DATE CANNOT BE AFTER THE TO DATE FOR OCCURRENCE SPAN CODES 1-12.* *Detail: Excludes denied claims with ARC 107. Occurrence span date = HI (01-12)-4 where HI(01-12)-1 = BI. If "FROM" date > "TO" date, then set edit.*				
HI12	C022	**Health Care Code Information**	O	Comp		Situational
		Description: To send health care codes and their associated dates, amounts and quantities				
HI12-01	1270	**Code List Qualifier Code**	M	ID	1/3	Required
		Description: Code identifying a specific industry code list				
HI12-02	1271	**Industry Code**	M	AN	1/30	Required

Description: Code indicating a code from a specific industry code list

HI12-03	1250	**Date Time Period Format Qualifier**	X	ID	2/3	Required

Description: Code indicating the date format, time format, or date and time format

HI12-04	1251	**Date Time Period**	X	AN	1/35	Required

Description: Expression of a date, a time, or range of dates, times or dates and times

Encounter Notes: *Error Message: THE FROM DATE CANNOT BE AFTER THE TO DATE FOR OCCURRENCE SPAN CODES 1-12.*

Detail: Excludes denied claims with ARC 107. Occurrence span date = HI (01-12)-4 where HI(01-12)-1 = BI. If "FROM" date > "TO" date, then set edit.

HI Value Information

Pos: 2310	Max: 2
Detail - Optional	
Loop: 2300	Elements: 12

User Option (Usage): Situational
Purpose: To supply information related to the delivery of health care

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
HI01	C022	**Health Care Code Information**	M	Comp		Required
		Description: To send health care codes and their associated dates, amounts and quantities				
HI01-01	1270	**Code List Qualifier Code**	M	ID	1/3	Required
		Description: Code identifying a specific industry code list				
HI01-02	1271	**Industry Code**	M	AN	1/30	Required
		Description: Code indicating a code from a specific industry code list **Encounter Notes:** *Error Message: TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO.* *Detail: TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present.*				
HI01-05	782	**Monetary Amount**	O	R	1/18	Required
		Description: Monetary amount **Encounter Notes:** *Error Message: MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY.* *Detail: If 2300 HI C022 (01 -12) -5 contains a negative value, reject the claim.* *Error Message: TOTAL DAYS BILLED INVALID.* *Detail: Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered days + non-covered days = (statement to-date minus statement from-date) + 1 or -1), do not set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date.*				
HI02	C022	**Health Care Code Information**	O	Comp		Situational
		Description: To send health care codes and their associated dates, amounts and quantities				
HI02-01	1270	**Code List Qualifier Code**	M	ID	1/3	Required
		Description: Code identifying a specific industry code list				
HI02-02	1271	**Industry Code**	M	AN	1/30	Required
		Description: Code indicating a code from a specific industry code list **Encounter Notes:** *Error Message: TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO.* *Detail: TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present.*				
HI02-05	782	**Monetary Amount**	O	R	1/18	Required
		Description: Monetary amount **Encounter Notes:** *Error Message: MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY.*				

Detail: If 2300 HI C022 (01 -12) -5 contains a negative value, reject the claim.

Error Message: TOTAL DAYS BILLED INVALID.

Detail: Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered days + non-covered days = (statement to-date minus statement from-date) + 1 or -1), do not set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date.

HI03	C022	**Health Care Code Information**	O	Comp		Situational

Description: To send health care codes and their associated dates, amounts and quantities

HI03-01	1270	**Code List Qualifier Code**	M	ID	1/3	Required

Description: Code identifying a specific industry code list

HI03-02	1271	**Industry Code**	M	AN	1/30	Required

Description: Code indicating a code from a specific industry code list
Encounter Notes: *Error Message: TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO.*

Detail: TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present.

HI03-05	782	**Monetary Amount**	O	R	1/18	Required

Description: Monetary amount
Encounter Notes: *Error Message: MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY.*

Detail: If 2300 HI C022 (01 -12) -5 contains a negative value, reject the claim.

Error Message: TOTAL DAYS BILLED INVALID.

Detail: Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered days + non-covered days = (statement to-date minus statement from-date) + 1 or -1), do not set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date.

HI04	C022	**Health Care Code Information**	O	Comp		Situational

Description: To send health care codes and their associated dates, amounts and quantities

HI04-01	1270	**Code List Qualifier Code**	M	ID	1/3	Required

Description: Code identifying a specific industry code list

HI04-02	1271	**Industry Code**	M	AN	1/30	Required

Description: Code indicating a code from a specific industry code list
Encounter Notes: *Error Message: TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO.*

Detail: TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present.

HI04-05	782	**Monetary Amount**	O	R	1/18	Required

Description: Monetary amount
Encounter Notes: *Error Message: MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY.*

Detail: If 2300 HI C022 (01 -12) -5 contains a negative value, reject the claim.

Error Message: TOTAL DAYS BILLED INVALID.

Detail: Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered days + non-covered days = (statement to-date minus statement from-date) + 1 or -1), do not set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date.

HI05	C022	**Health Care Code Information**	O	Comp		Situational

Description: To send health care codes and their associated dates, amounts and quantities

HI05-01	1270	**Code List Qualifier Code**	M	ID	1/3	Required

Description: Code identifying a specific industry code list

HI05-02	1271	**Industry Code**	M	AN	1/30	Required

Description: Code indicating a code from a specific industry code list
Encounter Notes: *Error Message: TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO.*

Detail: TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present.

HI05-05	782	**Monetary Amount**	O	R	1/18	Required

Description: Monetary amount
Encounter Notes: *Error Message: MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY.*

Detail: If 2300 HI C022 (01 -12) -5 contains a negative value, reject the claim.

Error Message: TOTAL DAYS BILLED INVALID.

Detail: Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered days + non-covered days = (statement to-date minus statement from-date) + 1 or -1), do not set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date.

HI06	C022	**Health Care Code Information**	O	Comp		Situational

Description: To send health care codes and their associated dates, amounts and quantities

HI06-01	1270	**Code List Qualifier Code**	M	ID	1/3	Required

Description: Code identifying a specific industry code list

HI06-02	1271	**Industry Code**	M	AN	1/30	Required

Description: Code indicating a code from a specific industry code list
Encounter Notes: *Error Message: TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO.*

Detail: TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present.

HI06-05	782	**Monetary Amount**	O	R	1/18	Required

Description: Monetary amount
Encounter Notes: *Error Message: MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY.*

Detail: If 2300 HI C022 (01 -12) -5 contains a negative value, reject the claim.

Error Message: TOTAL DAYS BILLED INVALID.

Detail: Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered days + non-covered days = (statement to-date minus statement from-date) + 1 or -1), do not set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date.

HI07	C022	**Health Care Code Information**	O	Comp		Situational

Description: To send health care codes and their associated dates, amounts and quantities

HI07-01	1270	**Code List Qualifier Code**	M	ID	1/3	Required

Description: Code identifying a specific industry code list

HI07-02	1271	**Industry Code**	M	AN	1/30	Required

Description: Code indicating a code from a specific industry code list
Encounter Notes: *Error Message: TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO.*

Detail: TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present.

HI07-05	782	**Monetary Amount**	O	R	1/18	Required

Description: Monetary amount
Encounter Notes: *Error Message: MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY.*

Detail: If 2300 HI C022 (01 -12) -5 contains a negative value, reject the claim.

Error Message: TOTAL DAYS BILLED INVALID.

Detail: Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered days + non-covered days = (statement to-date minus statement from-date) + 1 or -1), do not set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date.

HI08	C022	**Health Care Code Information**	O	Comp		Situational

Description: To send health care codes and their associated dates, amounts and quantities

HI08-01	1270	**Code List Qualifier Code**	M	ID	1/3	Required

Description: Code identifying a specific industry code list

HI08-02	1271	**Industry Code**	M	AN	1/30	Required

Description: Code indicating a code from a specific industry code list
Encounter Notes: *Error Message: TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO.*

Detail: TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present.

HI08-05	782	**Monetary Amount**	O	R	1/18	Required

Description: Monetary amount
Encounter Notes: *Error Message: MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY.*

Detail: If 2300 HI C022 (01 -12) -5 contains a negative value, reject the claim.

Error Message: TOTAL DAYS BILLED INVALID.

Detail: Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered days + non-covered days = (statement to-date minus statement from-date) + 1 or -1), do not set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date.

HI09	C022	**Health Care Code Information**	O	Comp		Situational

Description: To send health care codes and their associated dates, amounts and quantities

HI09-01	1270	**Code List Qualifier Code**	M	ID	1/3	Required

Description: Code identifying a specific industry code list

HI09-02	1271	**Industry Code**	M	AN	1/30	Required

Description: Code indicating a code from a specific industry code list
Encounter Notes: *Error Message: TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO.*

Detail: TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present.

HI09-05	782	**Monetary Amount**	O	R	1/18	Required

Description: Monetary amount
Encounter Notes: *Error Message: MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY.*

Detail: If 2300 HI C022 (01 -12) -5 contains a negative value, reject the claim.

Error Message: TOTAL DAYS BILLED INVALID.

Detail: Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered days + non-covered days = (statement to-date minus statement from-date) + 1 or -1), do not set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date.

HI10	C022	**Health Care Code Information**	O	Comp		Situational

Description: To send health care codes and their associated dates, amounts and quantities

HI10-01	1270	**Code List Qualifier Code**	M	ID	1/3	Required

Description: Code identifying a specific industry code list

HI10-02	1271	**Industry Code**	M	AN	1/30	Required

Description: Code indicating a code from a specific industry code list
Encounter Notes: *Error Message: TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO.*

Detail: TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present.

HI10-05	782	**Monetary Amount**	O	R	1/18	Required

Description: Monetary amount
Encounter Notes: *Error Message: MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY.*

Detail: If 2300 HI C022 (01 -12) -5 contains a negative value, reject the claim.

Error Message: TOTAL DAYS BILLED INVALID.

Detail: Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered days + non-covered days = (statement to-date minus statement from-date) + 1 or -1), do not set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date.

HI11	C022	**Health Care Code Information**	O	Comp		Situational

Description: To send health care codes and their associated dates, amounts and quantities

HI11-01	1270	**Code List Qualifier Code**	M	ID	1/3	Required

Description: Code identifying a specific industry code list

HI11-02	1271	**Industry Code**	M	AN	1/30	Required

Description: Code indicating a code from a specific industry code list
Encounter Notes: *Error Message: TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO.*

Detail: TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present.

HI11-05	782	**Monetary Amount**	O	R	1/18	Required

Description: Monetary amount
Encounter Notes: *Error Message: MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY.*

Detail: If 2300 HI C022 (01 -12) -5 contains a negative value, reject the claim.

Error Message: TOTAL DAYS BILLED INVALID.

Detail: Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered days + non-covered days = (statement to-date minus statement from-date) + 1 or -1), do not set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date.

HI12	C022	**Health Care Code Information**	O	Comp		Situational

Description: To send health care codes and their associated dates, amounts and quantities

HI12-01	1270	**Code List Qualifier Code**	M	ID	1/3	Required

Description: Code identifying a specific industry code list

HI12-02	1271	**Industry Code**	M	AN	1/30	Required

Description: Code indicating a code from a specific industry code list
Encounter Notes: *Error Message: TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO.*

Detail: TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present.

HI12-05	782	**Monetary Amount**	O	R	1/18	Required

Description: Monetary amount
Encounter Notes: *Error Message: MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY.*

Detail: If 2300 HI C022 (01 -12) -5 contains a negative value, reject the claim.

Error Message: TOTAL DAYS BILLED INVALID.

Detail: Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered days + non-covered days = (statement to-date minus statement from-date) + 1 or -1), do not set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date.

SBR Other Subscriber Information

Pos: 2900	Max: 1
Detail - Optional	
Loop: 2320	Elements: 5

User Option (Usage): Situational
Purpose: To record information specific to the primary insured and the insurance carrier for that insured

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
SBR01	1138	**Payer Responsibility Sequence Number Code**	M	ID	1/1	Required
		Description: Code identifying the insurance carrier's level of responsibility for a payment of a claim				
SBR02	1069	**Individual Relationship Code**	O	ID	2/2	Required
		Description: Code indicating the relationship between two individuals or entities				
SBR03	127	**Reference Identification**	O	AN	1/50	Situational
		Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier				
SBR04	93	**Name**	O	AN	1/60	Situational
		Description: Free-form name				
SBR09	1032	**Claim Filing Indicator Code**	O	ID	1/2	Situational
		Description: Code identifying type of claim **Encounter Notes:** *Error Message: Claim Filing Indicator Code Invalid, value of HM must be used.* *Detail: 2320/SBR09 must = HM, Health Maintenance Organization. Applies only to the MCC loop, not to Third Party Payer loops. The MCCID identifies the MCC loop as 2330B/REF02 when the 2330B/REF01=2U AND 2330B/REF02 has the first three bytes of MCC. If the 2330B loop does not contain this MCC ID, do not apply the edit to require the code.*				

CAS Claim Level Adjustments

Pos: 2950	Max: 5
Detail - Optional	
Loop: 2320	Elements: 19

User Option (Usage): Situational
Purpose: To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
CAS01	1033	**Claim Adjustment Group Code**	M	ID	1/2	Required
		Description: Code identifying the general category of payment adjustment				
CAS02	1034	**Claim Adjustment Reason Code**	M	ID	1/5	Required
		Description: Code identifying the detailed reason the adjustment was made **Encounter Notes:** *Error Message: VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE* *Detail: All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed:1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)*				
CAS03	782	**Monetary Amount**	M	R	1/18	Required
		Description: Monetary amount				
CAS04	380	**Quantity**	O	R	1/15	Situational
		Description: Numeric value of quantity				
CAS05	1034	**Claim Adjustment Reason Code**	X	ID	1/5	Situational
		Description: Code identifying the detailed reason the adjustment was made **Encounter Notes:** *Error Message: VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE* *Detail: All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed:1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)*				
CAS06	782	**Monetary Amount**	X	R	1/18	Situational
		Description: Monetary amount				
CAS07	380	**Quantity**	X	R	1/15	Situational
		Description: Numeric value of quantity				
CAS08	1034	**Claim Adjustment Reason Code**	X	ID	1/5	Situational
		Description: Code identifying the detailed reason the adjustment was made **Encounter Notes:** *Error Message: VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE* *Detail: All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed:1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)*				
CAS09	782	**Monetary Amount**	X	R	1/18	Situational
		Description: Monetary amount				
CAS10	380	**Quantity**	X	R	1/15	Situational

		Description: Numeric value of quantity				
CAS11	1034	**Claim Adjustment Reason Code**	X	ID	1/5	Situational
		Description: Code identifying the detailed reason the adjustment was made **Encounter Notes:** *Error Message: VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE* *Detail: All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed:1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)*				
CAS12	782	**Monetary Amount**	X	R	1/18	Situational
		Description: Monetary amount				
CAS13	380	**Quantity**	X	R	1/15	Situational
		Description: Numeric value of quantity				
CAS14	1034	**Claim Adjustment Reason Code**	X	ID	1/5	Situational
		Description: Code identifying the detailed reason the adjustment was made **Encounter Notes:** *Error Message: VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE* *Detail: All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed:1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)*				
CAS15	782	**Monetary Amount**	X	R	1/18	Situational
		Description: Monetary amount				
CAS16	380	**Quantity**	X	R	1/15	Situational
		Description: Numeric value of quantity				
CAS17	1034	**Claim Adjustment Reason Code**	X	ID	1/5	Situational
		Description: Code identifying the detailed reason the adjustment was made **Encounter Notes:** *Error Message: VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE* *Detail: All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed:1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)*				
CAS18	782	**Monetary Amount**	X	R	1/18	Situational
		Description: Monetary amount				
CAS19	380	**Quantity**	X	R	1/15	Situational
		Description: Numeric value of quantity				

AMT Coordination of Benefits (COB) Payer Paid Amount

Pos: 3000	Max: 1
Detail - Optional	
Loop: 2320	Elements: 2

User Option (Usage): Situational
Purpose: To indicate the total monetary amount

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
AMT01	522	**Amount Qualifier Code**	M	ID	1/3	Required
		Description: Code to qualify amount				
AMT02	782	**Monetary Amount**	M	R	1/18	Required
		Description: Monetary amount				

Encounter Notes: *Error Message: Capitated Claim (ARC 24) Not Allowed With Paid Amount Greater Than Zero*

Detail: Adjustment Reason Code (ARC) 24 is used by TennCare to indicate a capitated claim and/or detail. Placement of ARC 24 in the header CAS segment indicates that the entire claim is capitated. Capitated claims should not have a header or any detail paid amounts other than 0; otherwise, set a Normal edit. If a detail line is capitated – ARC 24 in detail level CAS - then the detail line should have a paid amount of 0; otherwise, set Normal edit status. If all details have an ARC 24 then the header is capitated and header level rules should apply. IF the 2330B loop REF01 = 2U where REF02 [1-3 bytes] = MCC. (This will eliminate non-MCC TPL loops).

Error Message: Denied Claim (ARC 107) Not Allowed With Paid Amount Greater Than Zero.

Detail: Adjustment Reason Code (ARC) 107 is used by TennCare to indicate a denied claim and/or detail. Placement of ARC 107 in the header CAS segment indicates that the entire claim is denied. Denied claims should not have a header or any detail paid amounts other than 0; otherwise, set a Normal edit. If a detail line is denied – ARC 107 in detail level CAS - then the detail line should have a paid amount of 0; otherwise, set Normal edit status. If all details have an ARC 107 then the header is denied and header level rules should apply. IF the 2330B loop REF01 = 2U where REF02 [1-3 bytes] = MCC. (This will eliminate non-MCC TPL loops)

Error Message: MCC PAID AMOUNT CANNOT BE GREATER THAN MCC ALLOWED AMOUNT - Allowed Amount 2320/AMT02.

Detail: Paid amount = 2320/AMT02 where AMT01=D(Payer Paid Amount). If paid amount > allowed amount, then error.

DTP Claim Check Or Remittance Date

Pos: 3500	Max: 1
Detail - Optional	
Loop: 2330B	Elements: 3

User Option (Usage): Situational
Purpose: To specify any or all of a date, a time, or a time period

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
DTP01	374	**Date/Time Qualifier**	M	ID	3/3	Required
		Description: Code specifying type of date or time, or both date and time				
DTP02	1250	**Date Time Period Format Qualifier**	M	ID	2/3	Required
		Description: Code indicating the date format, time format, or date and time format				
DTP03	1251	**Date Time Period**	M	AN	1/35	Required
		Description: Expression of a date, a time, or range of dates, times or dates and times				

Encounter Notes: *Error Message: REQUIRED MCC ADJUDICATION DATE MISSING - DATE 2330B/DTP03 Must Be Submitted (DTP01='573')*

Detail: Segment 2330B/DTP03 where DTP01=573 is required. This is mandatory for all transaction types. When the 2330B/DTP segment is missing, edit will set. Applies only to the MCC loop, not to Third Party Payer loops. The MCCID identifies the MCC loop as 2330B/REF02 when the 2330B/REF01=2U AND 2330B/REF02 has the first three bytes of MCC. If the 2330B loop does not contain this MCC ID, do not apply the edit to require MCC date.

Error Message: CLAIM ADJUDICATION DATE MUST BE GREATER THAN OR EQUAL TO FROM DATE OF SERVICE.

*Detail: Adjudication Date edits apply only to the MCC loops. Edits do not apply to other payer loops. If any claim service from date (837I: 2300/DTP03 where DTP01=434) is greater than the MCC Claim Adjudication Date (2330B/DTP where DTP01=573), then the claim is in error. Flag the error at the 2330B DTP02. The DTP02 should be inspected and if the DTP02=RD8, then the Begin date (FROM Date - the first date in the date range) should be used for comparing against the Adjudication Date. For example, if the DTP segment looked like "DTP*472*RD8*20080911-20080922" the Service date would be "20080911".*

Error Message: CLAIM ADJUDICATION DATE MUST BE GREATER THAN OR EQUAL TO THROUGH DATE OF SERVICE.

*Detail: Adjudication Date edits apply only to the MCC loops. Edits do not apply to other payer loops. If any claim service 'through' date (837I: 2300/DTP03 where DTP01=434) is greater than the MCC Claim Adjudication Date (2330B/DTP where DTP01=573), then the claim is in error. Flag the error at the 2330B DTP02. The DTP02 should be inspected and if the DTP02=RD8, then the End date (the last date in the date range) should be used for comparing against the Adjudication Date. For example, if the DTP segment looked like "DTP*472*RD8*20080911-20080922" the Service date would be "20080922".*

REF Other Payer Secondary Identifier

Pos: 3550	Max: 2
Detail - Optional	
Loop: 2330B	Elements: 2

User Option (Usage): Situational
Purpose: To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF01	128	**Reference Identification Qualifier**	M	ID	2/3	Required
		Description: Code qualifying the Reference Identification				
REF02	127	**Reference Identification**	X	AN	1/50	Required
		Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier				

Encounter Notes: *Error Message: REQUIRED ENCOUNTER SEGMENT MISSING - TennCare requires at least one 2330B/REF02 segment with REF01=2U for Encounter Claims.*

Detail: Edit will verify that one REF segment at the 2330B level with a REF01=2U, with the first 3 bytes = MCC, is present to indicate the MCC ID.

Error Message: MISSING OR INVALID TPL CARRIER CODE - NOT VALID FOR TENNCARE (Data in 2330B REF02 not on TennCare code list).

Detail: TennCare Requires the MCC to use valid Third Party Liability carrier codes when reporting TPL payments. Verify that the value submitted in 2330B/REF02 if REF01=2U is contained on the table. If not, set the edit. Must use TN table of carrier codes as a custom code list.

REF Other Payer Claim Control Number

Pos: 3550	Max: 1
Detail - Optional	
Loop: 2330B	Elements: 2

User Option (Usage): Situational
Purpose: To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF01	128	**Reference Identification Qualifier**	M	ID	2/3	Required
		Description: Code qualifying the Reference Identification				
REF02	127	**Reference Identification**	X	AN	1/50	Required
		Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier				
		Encounter Notes: *Error Message: REQUIRED MCC ICN MISSING OR INVALID - 2330B/REF02 Must Contain a Valid Internal Control Number* *Detail: Mandatory element for MCC loop. If 2330B/REF02=0's or 9's or blank, If REF01 = F8. This edit should set if the qualifier is F8 and the REF02 is zeros or all nines or if missing. Applies only to the MCC loop, not to Third Party Payer loops. The MCCID identifies the MCC loop as 2330B/REF02 when the 2330B/REF01=2U AND 2330B/REF02 has the first three bytes of MCC. If the 2330B loop does not contain this MCC ID, do not apply the edit to require the ICN.*				

SV2 Institutional Service Line

Pos: 3750	Max: 1
Detail - Optional	
Loop: 2400	Elements: 6

User Option (Usage): Required
Purpose: To specify the service line item detail for a health care institution

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
SV201	234	**Product/Service ID**	X	AN	1/48	Required
		Description: Identifying number for a product or service				
SV202	C003	**Composite Medical Procedure Identifier**	X	Comp		Situational
		Description: To identify a medical procedure by its standardized codes and applicable modifiers				
SV202-01	235	**Product/Service ID Qualifier**	M	ID	2/2	Required
		Description: Code identifying the type/source of the descriptive number used in Product/Service ID (234)				
SV202-02	234	**Product/Service ID**	M	AN	1/48	Required
		Description: Identifying number for a product or service				
SV202-03	1339	**Procedure Modifier**	O	AN	2/2	Situational
		Description: This identifies special circumstances related to the performance of the service, as defined by trading partners				
SV202-04	1339	**Procedure Modifier**	O	AN	2/2	Situational
		Description: This identifies special circumstances related to the performance of the service, as defined by trading partners				
SV202-05	1339	**Procedure Modifier**	O	AN	2/2	Situational
		Description: This identifies special circumstances related to the performance of the service, as defined by trading partners				
SV202-06	1339	**Procedure Modifier**	O	AN	2/2	Situational
		Description: This identifies special circumstances related to the performance of the service, as defined by trading partners				
SV202-07	352	**Description**	O	AN	1/80	Situational
		Description: A free-form description to clarify the related data elements and their content				
SV203	782	**Monetary Amount**	O	R	1/18	Required
		Description: Monetary amount				
SV204	355	**Unit or Basis for Measurement Code**	X	ID	2/2	Required
		Description: Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken				
SV205	380	**Quantity**	X	R	1/15	Required
		Description: Numeric value of quantity **Encounter Notes:** *Error Message: ITEM DAYS MUST EQUAL COVERED DAYS ON CLAIM - For Accommodation Revenue Code 0100 Through 0219, Item Days(2400/SV205) Must Equal Header Covered days(Where value code = 80)* *Detail: Excludes denied claims with ARC 107. Item Days = 2400/SV205. Covered days = Value Code 80. If the Item Days do not equal to covered days, then it is an error. The edit is limited to Accommodation Revenue codes of 0100-0219 or 1000-1005. All other codes should*				

		not set this edit. The edit will set if the sum of the units billed on the claim lines for any of the above revenue codes is not equal to the covered days in the header. If txn has days billed in the QTY segments (>0) but have no LX lines with Rev code 0100 - 0219 or 1000-1005, it should set the edit. If txn has Rev codes 0100 - 0219 or 1000-1005 and no QTY, or count doesn't match, then set the edit. If txn has no QTY segment and no Rev code with 0100 - 0219 or 1000-1005, then don't set the edit.				
SV207	782	**Monetary Amount** **Description:** Monetary amount	O	R	1/18	Situational

DTP Date - Service Date

Pos: 4550	Max: 1
Detail - Optional	
Loop: 2400	Elements: 3

User Option (Usage): Situational
Purpose: To specify any or all of a date, a time, or a time period

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
DTP01	374	**Date/Time Qualifier**	M	ID	3/3	Required
		Description: Code specifying type of date or time, or both date and time				
DTP02	1250	**Date Time Period Format Qualifier**	M	ID	2/3	Required
		Description: Code indicating the date format, time format, or date and time format				
DTP03	1251	**Date Time Period**	M	AN	1/35	Required
		Description: Expression of a date, a time, or range of dates, times or dates and times				

Encounter Notes: *Error Message: DETAIL SERVICE DATES MUST BE WITHIN HEADER SERVICE DATE RANGE - Dates 2400/DTP03 Must Be Within Date Range In 2300/DTP03.*

Detail: Excludes denied claims with ARC 107. Header service (statement) date = 2300/DTP03 where DTP01 = 434, Detail service date = 2400/DTP03 where DTP01 = 472). When the detail service date is same as header dates, no error should be reported.

Error Message: ENCOUNTER DATE OF SERVICE CANNOT BE GREATER THAN MCC RECEIPT DATE (2300/K301).

*Detail: The edit applies to both dates in the 837I. If any service date (837I: 2300/DTP03 where DTP01=434 or 837I: 2400/DTP03 where DTP01=472) is greater than the MCC Receipt Date (2300/K301), then that service date is in error. The DTP02 should be inspected and if the DTP02=RD8, then the Begin date (the first date in the date range) should be used for comparing against the Receipt Date. For example, if the DTP segment looked like "DTP*472*RD8*20060911-20060922" the Service date would be "20060911".*

LIN Drug Identification

Pos: 4930	Max: 1
Detail - Optional	
Loop: 2410	Elements: 2

User Option (Usage): Situational
Purpose: To specify basic item identification data

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
LIN02	235	**Product/Service ID Qualifier**	M	ID	2/2	Required
		Description: Code identifying the type/source of the descriptive number used in Product/Service ID (234)				
LIN03	234	**Product/Service ID**	M	AN	1/48	Required
		Description: Identifying number for a product or service				

Encounter Notes:

Error Message: NDC MISSING – TENNCARE REQUIRED (2410 LIN) WHEN HCPCS J-CODE IS PRESENT ON SERVICE LINE.

Detail: If 2400 SV2-2 or SV1-2 on the service line begins with an alpha J and no 2410 LIN is found on the same service line, set the edit. Exclude inpatient claims on the 837I.

CTP Drug Quantity

Pos: 4940	Max: 1
Detail - Optional	
Loop: 2410	Elements: 2

User Option (Usage): Required
Purpose: To specify pricing information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
CTP04	380	**Quantity**	X	R	1/15	Required
		Description: Numeric value of quantity				
CTP05	C001	**Composite Unit of Measure**	X	Comp		Required
		Description: To identify a composite unit of measure (See Figures Appendix for examples of use)				
CTP05-01	355	**Unit or Basis for Measurement Code**	M	ID	2/2	Required
		Description: Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken				

Encounter Notes:

Error Message: 2410 CTP SEGMENT MISSING – REQUIRED BY TENNCARE WHEN THE HCPCS J-CODE IS PRESENT.

Detail: If a HCPCS J-Code is present in the service line with an NDC (2410 LIN03) the 2410 CTP segment is required on the same service line. Inpatient claims on 837I should be excluded from this edit.

SVD Line Adjudication Information

Pos: 5400	Max: 1
Detail - Optional	
Loop: 2430	Elements: 5

User Option (Usage): Situational
Purpose: To convey service line adjudication information for coordination of benefits between the initial payers of a health care claim and all subsequent payers

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
SVD01	67	**Identification Code**	M	AN	2/80	Required
		Description: Code identifying a party or other code				
SVD02	782	**Monetary Amount**	M	R	1/18	Required
		Description: Monetary amount **Encounter Notes:** *Error Message: Capitated Claim (ARC 24) Not Allowed With Paid Amount Greater Than Zero* *Detail: Adjustment Reason Code (ARC) 24 is used by TennCare to indicate a capitated claim and/or detail. Placement of ARC 24 in the header CAS segment indicates that the entire claim is capitated. Capitated claims should not have a header or any detail paid amounts other than 0; otherwise, set a Normal edit. If a detail line is capitated – ARC 24 in detail level CAS - then the detail line should have a paid amount of 0; otherwise, set Normal edit status. If all details have an ARC 24 then the header is capitated and header level rules should apply. IF the 2330B loop REF01 = 2U where REF02 [1-3 bytes] = MCC. (This will eliminate non-MCC TPL loops).* *Error Message: Denied Claim (ARC 107) Not Allowed With Paid Amount Greater Than Zero.* *Detail: Adjustment Reason Code (ARC) 107 is used by TennCare to indicate a denied claim and/or detail. Placement of ARC 107 in the header CAS segment indicates that the entire claim is denied. Denied claims should not have a header or any detail paid amounts other than 0; otherwise, set a Normal edit. If a detail line is denied – ARC 107 in detail level CAS - then the detail line should have a paid amount of 0; otherwise, set Normal edit status. If all details have an ARC 107 then the header is denied and header level rules should apply. IF the 2330B loop REF01 = 2U where REF02 [1-3 bytes] = MCC. (This will eliminate non-MCC TPL loops)*				
SVD03	C003	**Composite Medical Procedure Identifier**	O	Comp		Required
		Description: To identify a medical procedure by its standardized codes and applicable modifiers				
SVD03-01	235	**Product/Service ID Qualifier**	M	ID	2/2	Required
		Description: Code identifying the type/source of the descriptive number used in Product/Service ID (234)				
SVD03-02	234	**Product/Service ID**	M	AN	1/48	Required
		Description: Identifying number for a product or service				
SVD03-03	1339	**Procedure Modifier**	O	AN	2/2	Situational
		Description: This identifies special circumstances related to the performance of the service, as defined by trading partners				
SVD03-04	1339	**Procedure Modifier**	O	AN	2/2	Situational
		Description: This identifies special circumstances related to the performance of the service, as defined by trading partners				
SVD03-05	1339	**Procedure Modifier**	O	AN	2/2	Situational

		Description: This identifies special circumstances related to the performance of the service, as defined by trading partners				
SVD03-06	1339	**Procedure Modifier**	O	AN	2/2	Situational
		Description: This identifies special circumstances related to the performance of the service, as defined by trading partners				
SVD03-07	352	**Description**	O	AN	1/80	Situational
		Description: A free-form description to clarify the related data elements and their content				
SVD05	380	**Quantity**	O	R	1/15	Required
		Description: Numeric value of quantity				
SVD06	554	**Assigned Number**	O	N0	1/6	Situational
		Description: Number assigned for differentiation within a transaction set				

CAS Line Adjustment

Pos: 5450	Max: 5
Detail - Optional	
Loop: 2430	Elements: 19

User Option (Usage): Situational
Purpose: To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
CAS01	1033	**Claim Adjustment Group Code**	M	ID	1/2	Required
		Description: Code identifying the general category of payment adjustment				
CAS02	1034	**Claim Adjustment Reason Code**	M	ID	1/5	Required
		Description: Code identifying the detailed reason the adjustment was made **Encounter Notes:** *Error Message: VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE* *Detail: All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed:1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)*				
CAS03	782	**Monetary Amount**	M	R	1/18	Required
		Description: Monetary amount				
CAS04	380	**Quantity**	O	R	1/15	Situational
		Description: Numeric value of quantity				
CAS05	1034	**Claim Adjustment Reason Code**	X	ID	1/5	Situational
		Description: Code identifying the detailed reason the adjustment was made **Encounter Notes:** *Error Message: VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE* *Detail: All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed:1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)*				
CAS06	782	**Monetary Amount**	X	R	1/18	Situational
		Description: Monetary amount				
CAS07	380	**Quantity**	X	R	1/15	Situational
		Description: Numeric value of quantity				
CAS08	1034	**Claim Adjustment Reason Code**	X	ID	1/5	Situational
		Description: Code identifying the detailed reason the adjustment was made **Encounter Notes:** *Error Message: VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE* *Detail: All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed:1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)*				
CAS09	782	**Monetary Amount**	X	R	1/18	Situational
		Description: Monetary amount				
CAS10	380	**Quantity**	X	R	1/15	Situational

		Description: Numeric value of quantity				
CAS11	1034	**Claim Adjustment Reason Code**	X	ID	1/5	Situational
		Description: Code identifying the detailed reason the adjustment was made **Encounter Notes:** *Error Message: VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE* *Detail: All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed:1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)*				
CAS12	782	**Monetary Amount**	X	R	1/18	Situational
		Description: Monetary amount				
CAS13	380	**Quantity**	X	R	1/15	Situational
		Description: Numeric value of quantity				
CAS14	1034	**Claim Adjustment Reason Code**	X	ID	1/5	Situational
		Description: Code identifying the detailed reason the adjustment was made **Encounter Notes:** *Error Message: VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE* *Detail: All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed:1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)*				
CAS15	782	**Monetary Amount**	X	R	1/18	Situational
		Description: Monetary amount				
CAS16	380	**Quantity**	X	R	1/15	Situational
		Description: Numeric value of quantity				
CAS17	1034	**Claim Adjustment Reason Code**	X	ID	1/5	Situational
		Description: Code identifying the detailed reason the adjustment was made **Encounter Notes:** *Error Message: VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE* *Detail: All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed:1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)*				
CAS18	782	**Monetary Amount**	X	R	1/18	Situational
		Description: Monetary amount				
CAS19	380	**Quantity**	X	R	1/15	Situational
		Description: Numeric value of quantity				

DTP Line Check or Remittance Date

Pos: 5500	Max: 1
Detail - Optional	
Loop: 2430	Elements: 3

User Option (Usage): Required
Purpose: To specify any or all of a date, a time, or a time period

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
DTP01	374	**Date/Time Qualifier**	M	ID	3/3	Required
		Description: Code specifying type of date or time, or both date and time				
DTP02	1250	**Date Time Period Format Qualifier**	M	ID	2/3	Required
		Description: Code indicating the date format, time format, or date and time format				
DTP03	1251	**Date Time Period**	M	AN	1/35	Required
		Description: Expression of a date, a time, or range of dates, times or dates and times				

Encounter Notes: *Error Message: SERVICE LINE ADJUDICATION DATE MUST BE GREATER THAN OR EQUAL TO FROM DATE OF SERVICE.*

*Detail: Adjudication Date edits apply only to the MCC loops. Edits do not apply to other payer loops. If any 'from' service date (837I: 2400/DTP03 where DTP01=472) is greater than the line adjudication date (2430/DTP where DTP01=573), then that date is in error. Flag the error at the 2430 DTP02. The DTP02 should be inspected and if the DTP02=RD8, then the Begin date (FROM-the first date in the date range) should be used for comparing against the Adjudication Date. For example, if the DTP segment looked like "DTP*472*RD8*20080911-20080922" the Service date would be "20080911".*

Error Message: SERVICE LINE ADJUDICATION DATE MUST BE GREATER THAN OR EQUAL TO THROUGH DATE OF SERVICE.

*Detail: Adjudication Date edits apply only to the MCC loops. Edits do not apply to other payer loops. If any end (FROM) service date (837I: 2400/DTP03 where DTP01=472) is greater than the line adjudication date (2430/DTP where DTP01=573), then that date is in error. Flag the error at the 2430 DTP02. The DTP02 should be inspected and if the DTP02=RD8, then the END date (the last date in the date range) should be used for comparing against the Adjudication Date. For example, if the DTP segment looked like "DTP*472*RD8*20080911-20080922" the Service date would be "20080922".*